Patient Health History

All information taken by our team is confidential and will be used for the purpose of enhancing your care in the clinic.

Contact information

Name *FIRST & LAST*			Date of Birth *DD/MM/YYYY*
Street address			
City	Province	Postal Code	Preferred Contact ◯ Cell ◯ Home ◯ E-mail ◯ Work
Cell	Home Ph.	Work Ph.	
Email		Occupation	
Primary Complaint		Referred by	
CareCard #		Extended Medical Insurer	

Check all that apply

- ◯ chronic cough
- ◯ shortness of breath
- ◯ bronchitis
- ◯ asthma
- ◯ emphysema
- ◯ pneumonia
- ◯ high blood pressure
- ◯ low blood pressure
- ◯ heart disease
- ◯ heart attack
- ◯ phlebitis
- ◯ stroke / CVA
- ◯ congestive heart failure
- ◯ pacemaker
- ◯ skin condition (contagious or non-contagious)
- ◯ varicose veins
- ◯ loss of sensation
- ◯ numbness or tingling
- ◯ diabetes
- ◯ allergies
- ◯ epilepsy
- ◯ arthritis
- ◯ vision loss
- ◯ vision problems
- ◯ hearing loss
- ◯ hearing problems
- ◯ vertigo
- ◯ benign or malignant tumor
- ◯ hepatitis
- ◯ hemophilia
- ◯ tuberculosis
- ◯ human immuno deficiency virus (HIV)
- ◯ pregnancy
- ◯ internal pins, plates, wires, artificial joints, etc.
- ◯ other _____
- ◯ muscle or joint discomfort in:
- ◯ head
- ◯ neck
- ◯ upper back
- ◯ mid back
- ◯ low back
- ◯ shoulders
- ◯ arms
- ◯ hands
- ◯ hips
- ◯ knees
- ◯ legs
- ◯ feet
- ◯ other _____

Medical history

What is your general health status?

Hours of physical activity per week?

Any allergies?

What other health care therapies do you receive? *CHIROPRACTIC, PHYSIOTHERAPY, ETC.*

List all current medications and conditions they treat:

List any previous surgeries and dates:

Do you have a family history of: ◯ heart disease ◯ arthritis ◯ cancer ◯ diabetes ◯ osteoporosis

Primary care physician:

Contact info:

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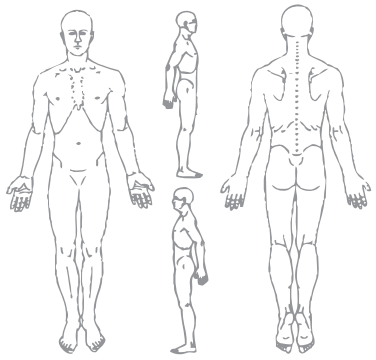
Specific case history

Primary complaint

Please circle the area(s) of concern on the adjacent diagram →

How did it happen?



Is this the first time this has happened?

Is the pain ◯ **LOCAL** to the area, or does it ◯ **TRAVEL**?

How long has it been a problem?

Is the pain ◯ **CONSTANT** or does it ◯ **COME AND GO**?

Identify the severity of your pain no pain 0 1 2 3 4 5 6 7 8 9 10 excruciating pain

Describe the pain *SHARP, DULL, ACHING, BURNING ETC.*

Aggravating factors

Relieving factors

Have you received any chiropractic / physiotherapy / massage treatments for this complaint? *PROVIDE DETAILS*

Have you received any conventional drug and / or medical treatment for this complaint? *PROVIDE DETAILS*

Any past trauma / accidents to this area?

Any unexplained weight loss recently?

Any unexplained fever or night sweats?

Can you sleep through the night?

Patient declaration

Well + Able Integrated Health requires 24 hours notice to reschedule or cancel any massage appointment. Appointments missed or cancelled with insufficient notice may be billed for the full service fee.

◯ I certify that the above information is correct and complete.

Date *DD/MM/YYYY*

Patient signature:

Clinician signature:

well+able
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